NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER Health Services STATEMENT NUMBER 6.17
SUBJECT: **INMATE DISCHARGE/TRANSFER SUMMARIES**	EFFECTIVE DATE 11/15/03 REVIEW DATE 07/15/04 SUPERSEDES PPD# 6.17 DATED 09/01/02
ISSUING OFFICER: _____	DIRECTOR'S INITIALS _____ APPENDIX ATTACHED: YES _____ NO _____
REFERENCE NO: See reference section on last page of PPD.	

I. PURPOSE:
To provide the current medical, mental health and dental status of transferring inmates to the receiving institution..

II. APPLICABILITY:
To all employees of the medical, mental health and dental sections, transportation team, classification officer and inmates being transferred.

III. POLICY:
It is the policy of the Department of Corrections to prepare a Transfer/Discharge Summary to be sent with the offender record of every inmate being transferred to another institution.

IV. PROCEDURE:

A. The following offices will provide written notification at least 7 working days in advance of a scheduled transfer of an inmate to another facility:
   1. The Classification for county transfers
   2. The Interstate Compact Office for out of state transfer

   In the event that notice is not available the appropriate office shall notify Medical/Mental Health/Dental as soon as practical.

B. Health Services/Mental Health will complete the discharge/transfer summary (attachment 1) and send it to Classification for county transfers or the Interstate Compact Office for out of state transfers, where a packet of all relative inmate data will be prepared and given to the Transportation Team for delivery. If the transferee has already left, the discharge/transfer summary shall be mailed or faxed to the gaining facility as soon as practical. The original summary will be given to the receiving facility. One copy will be provided to the transporting officers and one copy will be filed in the inmate's medical record.

REFERENCES:

Standards for the Administration of Correctional Agencies
Second Edition. Standards

Standards for Adult Correctional Institutions
Fourth Edition Standards
4-4414

Standards for Adult Community Residential Services
Fourth Edition. Standards
4-ACRS-4C-24

Standards for Adult Probation and Parole Field Services
Third Edition. Standards

Other

MACLEOD/pf

Attachment

NEW HAMPSHIRE DEPARTMENT OF CORRECTIONS

TRANSFER/DISCHARGE SUMMARY

Patient Name _____ ID # _____ Date of Birth _____

Date of last physical exam _____ Date of last tuberculin test and results _____

KNOWN ALLERGIES (foods, medicines, etc.)

SIGNIFICANT HEALTH PROBLEMS NOTED PRIOR TO ADMISSION (include treatment given and where given if available)

SIGNIFICANT HEALTH PROBLEMS NOTED DURING STAY (include dates and treatment)

MEDICATIONS TAKEN AT TIME OF DISCHARGE

RESTRICTIONS (if any) PLEASE SPECIFY

Activities

Diet

Housing

Other

ADDITIONAL COMMENTS

Signature and title Date

Attach additional sheets if necessary

MENTAL HEALTH TRANSFER SUMMARY

HAS THERE BEEN A SUICIDE ATTEMPT OR GESTURE DURING CURRENT OR PRIOR INCARCERATIONS?

YES NO

DATE OF LAST ATTEMPT OR GESTURE _____/_____/_____

DESCRIPTION OF ATTEMPT OR GESTURE

DURING THIS CURRENT PERIOD OF INCARCERATION DID THIS INMATE RECEIVE INCREASED OBSERVATION FOR MENTAL HEALTH REASONS?

YES NO

IF YES, DESCRIBE

PRIOR PSYCHIATRIC INPATIENT HISTORY?

YES NO

IF YES, WHO WAS PROVIDER?

NAME OF PROVIDER:
PHONE NUMBER:

CURRENT PSYCHOTROPIC MEDICATONS:

MEDICATION	DOSAGE

IS INMATE CURRENTLY RECEIVING MENTAL HEALTH SERVICES?

YES NO

IF YES, DESCRIBE SCOPE OF SERVICES AND PROVIDER

ATTACH ADDITIONAL SHEETS IF NECESSARY

Cc: Transporting Officer
Medical Record